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ABSTRACT

In the past 15-20 years drug use in U.S. society has increased among women of childbearing age. Therefore, the task facing multidisciplinary professionals (physicians, social workers, psychologists, drug rehabilitation workers) is much more comprehensive than ever before. All practitioners need to understand the service provided to women in recovery and their families. Substance abuse undermines normal patterns of interaction and alters commitment priorities. Similarities present in substance abusing families may include poor parenting skills, unreasonably high expectations for their children, lack of supervision, lax/coercive disciplinary techniques, social isolation, lack of cohesion, family psychological problems, antisocial behaviors, stress, and conflict. An individual raised in a dysfunctional (alcoholic, substance abusing, abusive) family develops characteristics of rigidity, silence, denial, and isolation. Recovery and rehabilitation from cocaine and/or other licit and illicit substance abuse may include programs incorporating all or some of the following methods: detoxification from the substance(s); individual and group psychotherapy; family support and intervention; vocational and/or educational preparation; parent-skill training; early intervention programs for drug-exposed young children; and Twelve Step Support Groups. Although some maternal addicts seek voluntary rehabilitation for their illness, others are involuntarily retained by the judicial system. Problematic conditions place cocaine/polydrug exposed young children at high risk for organismic (related to birth) and environmental stressors (caregiving), and synergistically magnify vulnerability to the perpetuated, generational dysfunction. (Four case studies are included). (ABL)

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School Expectations From the Drug Using Family: Assisting and Understanding the Child and the Home

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TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC).

In the past 15-20 years, drug use in our society has increased among women of childbearing age. Therefore, the task facing multidisciplinary professionals (physicians, social workers, psychologists, and drug rehabilitation workers) is much more comprehensive than ever before. All practitioners need to understand the service provided to women in-recovery and their families.

Substance abuse undermines normal patterns of interaction and alters commitment priorities. Drugs give temporary meaning and significance to the lives of addicts by deadening painful feelings such as low self-esteem and depression; drugs create the ability to deal with emotional burdens and lack of assertiveness (Friedman, 1974; Hirsch & Imhoff; Kaufman & Kaufman, 1979).

Cocaine is usually taken in combination with other drugs including alcohol, heroin, marijuana, tobacco, barbituates, and/or amphetamines according to Gawin (1991, p. 1581):

> "The fundamental effect of cocaine is the magnification of the intensity of almost all normal pleasure. The environment takes on an intensified but non-distorted qualities. Emotional and sexual feelings are enhanced. Self-confidence and self-perception of mastery increase, so anxiety is initially decreased. Social inhibitions are reduced, and interpersonal communication is facilitated. Satiation of appetite occurs, so pleasures associated with eating are not enhanced."

Similarities present in substance abusing families may include the following: poor parenting skills, unreasonably high expectations for their children, lack of supervision, lax/coercive disciplinary techniques, social isolation, lack of cohesion, family psychological problems, antisocial behaviors, stress, and conflict (Kandell, 1990). "Heavy drug use and especially addiction interferes with a mother's ability to provide consistent nurturing and caretaking needed to promote children's development, self-esteem, and ability to regulate their affect or impulses" (Zuckerman, 1991b, p. 3). The origin of addiction has many theories; however a growing body of evidence indicates many addicted women have been sexually and/or physically abused as children. Research indicates a high incidence of incest, and estimates run from 50-90 percent of maternal addicts were sexually abused as children (Textor, 1987; Zuckerman, 1991).

An individual raised in a dysfunctional (alcoholic, substance abusing, abusive) family develops characteristics of rigidity, silence, denial, and isolation, specific characteristics which describe a closed system (Kritsberg, 1985). Dysfunctional families operate by inhibiting any change in its members; therefore, the family is rendered inflexible. Children raised in a dysfunctional or substance abusing family need to control other people when they reach adulthood. The methods they select to control their own children are generational - the perpetuation of their own childhood abuse projected onto their children. Denial is another manifestation of generation dysfunction and occurs when family members deny what they are feeling. With silence imposed, family members remain mute, and do not discuss what is happening in the family to one another or with people outside the family unit. This imposed quietness produces deep feelings of loneliness. The dysfunctional and/or addictive family is a closed system. Bonding and interaction did not develop, a direct correlation with the inflexibility and denial of lifestyles (See Table 1).

Recovery and rehabilitation from cocaine and/or other licit and illicit substance abuse may include programs incorporating all or some of the following methods: detoxification from the substance(s), individual and group psychotherapy, family support and intervention, vocational and/or educational preparation, parent-skill training, early intervention programs for drug-exposed young children, and Twelve Step Support Groups (Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, Co-Dependents Anonymous, Adult Children of Alcoholics, etc.). The purpose and tradition of Twelve Step Programs is to develop a bond of support with other participants, reduce the incidence of relapse, and develop an understanding of past, present, and future self-relationships with the accompanying knowledge of addictive-dysfunctional behavior.

Although some maternal addicts seek voluntary rehabilitation for their illness, others are involuntarily retained by the judicial system. This occurs when medical or social service professionals, following procedural safeguards, detect child abuse and/or neglect, a result of the mother's continual use of cocaine/polydrugs. Positive identification of fetal drug-exposure can be detected by medical professionals through the use of maternal histories which signal substance abuse, fetal withdrawal, urine toxicology testing of the

mother and newborn, and meconium testing of the newborn's first bowel movement (See Table 2).

As previously documented in the discussion concerning generational dysfunction, the perpetuation of child abuse is demonstrated in social service and medical records which are maintained for the cocaine/polydrug exposed child and family, a legacy of many dysfunctional families. This dysfunction may be due to the non-normative stressors encountered in the lives of substance abusing families, a coping mechanism they developed in response to invasive internal and external stimuli (See Table 3).

Child abuse, with a pathological locus of control in the family of origin, results from the perpetuation of unclear messages, vague information giving, lack of direct talk, avoidance of eye contact, frequent interruptions, illicit and/or licit substance abuse, and speaking for others (Textor, 1987). Cocaine/polydrug addicted parents, similar to other child abusers, typically received little love or tenderness and were frequently abused as children; as substance abusing parents, they combine a high level of demand with a great desire for immediate response (Adams, 1986). Young children are especially vulnerable. They are the most defenseless, least able to communicate their reactions and fears and are thought by parents and others that they will "forget" the experience of repeated exposure to violence (Zuckerman, 1991). These problematic conditions place cocaine/polydrug exposed young children at high risk for organismic (related to birth) and environmental stressors (caregiving), and synergistically magnify vulnerability to the perpetuated, generational dysfunction (O'Grady & Metz, 1987).

Meeting the Mothers (Actual Case Studies)

Child PT, (d.o.b 10-16-89) Number 1
Social History

PT is a black male, the third child born to his mother, R_____. R_____ was expelled from the 11th grade for strong-armed robbery of another girl's money. R_____'s behavior is described as "destructive and manipulative". She is smart, especially in the ways of the street.

R_____ has been described by her social worker as a drug dealer who made up to $1,500 - $2,000 per night selling crack cocaine. Even though she had 3 children (the two older siblings, aged 9 and 16, are in the custody of relatives), R_____ iss considered to be bisexual. She often has a "girlfriend" staying with her. R_____ described herself as self-employed. Sometimes she prostituted her body (criminal record) to get an "egg" or "rock" which was worth $15 on the streets. As a dealer, she was financially secure and was able to purchase elaborate furniture and extravagant clothing for her children.

PT's birth father, age 49, was married to another woman at the time of PT's birth. R_____ protected the father's identity by refusing to name him. The father attended college for three years, and was employed as a supervisor. He was described as 6 feet tall, and soft spoken.

After R_____ failed to complete two drug treatment programs, she was tried by the County Solicitor. Her record included prostitution, petty larceny, armed robbery, assault, and contributing to the abuse and neglect of PT, born exposed to cocaine, alcohol, and barbituates. R_____ was sentenced to 10 years in prison, an extremely long incarceration which was provoked by her belligerent outbursts and behavior toward the Solicitor.

R_____ experienced a sense of loss for PT, her son. Letters were sent from prison to her caseworker, on a regular basis;

> "I am sending you this card, so please give it to PT. Please bring him this month is you can. I look at picture of him every night."
> "I regret that I didn't follow through with my treatment. E (caseworker), I was angry with you, but you was only trying to help me more than anything. Please forgive my negative attitude. You were the best social worker I ever had. God bless you and your family. I don't want to loose PT. Give him a hug and a big kiss. I'm having a very hard time with these ladies picking at me and saying I had a 'crack baby', and that DSS took him. That hurts. I got to see him. I'm depressed. I hope they haven't taken my rights as PT's mother. I will go crazy. I go to church every Sunday and at night when they call it. I'm a good inmate."

"Tell PT's foster family I'm very grateful of their love for my son and I sent $15 a month to show that I want to do something for him. I get a state check every two weeks, not much, but I'll save that just to send PT. Can he talk how? I LOVE HIM NO MATTER WHAT. I was used as an example so other women would know don't use drugs, pregnant or not."

Caseworker interjections into the document indicate that R_ is smart and just using PT as a means of being released from prison. PT has difficulty recognizing his mother when the caseworker takes him to the prison. The problem is his young age and inability to bond with his mother whom he rarely sees.

BB (d.o.b. 8-13-89)

BB was placed into protective custody of the Department of Social Services because of her mother's physical neglect by drug exposure to the infant girl. BB was described by her caseworker to be "a very bright, attractive child," (2-28-90). "Mother can't get clean urine" is also noted by the worker.

"Mother was very shaky and her eyes were glazed over," wrote the caseworker. The worker suggested a Dtox program (7-13-91). An older female sibling has been placed for adoption. BB and sibling, a male, were both born cocaine-exposed. Both are in protective custody having been removed by the local police department with the charge to their mother of felonious criminal neglect due to endangering a child's life.

DB (d.o.b. 9-29-89)

DB was born in a comode during a crack-cocaine binge his mother was on. He and his mother were both transported to GHS by Emergency Medical Technicians after the newborn found.

The local hospital system declared DB to be "at-risk" when cocaine/polydrugs were found in his urine. This was in violation of South Carolina Code 26-7-650.

DB was described as extremely jittery and shakey and as experiencing severe drug withdrawal. Child had scratches and marks on his nose and face from his fierce movements and restlessness. (Hospital visit 10-13-89).

A cat scan found a little fluid on the brain (12-1-89).

DB is a perfect example of a drug addicted baby. He is unconsolable and consequently fed bottles and food to quite him. He also has deformed ears (Drug Rehabilitation Worker on 7-10-90).

Mother has dirty urine serum from smoking marijuana (2 6-91).

Two dirty urines in drug program Monday and Thursday (3-5-91).

Mother not honest which is typical of drug using mothers. She cares for DB, but she also neglects him. Custody removed from mother and given to maternal grandmother. Mother feels custody needs to be returned; however, a stroke following a cocaine binge has left her right side paralyzed. Mother's father died from drug abuse problems after using Coke for 4 years (5-17-91).

MD (9-11-89) (d.o.b. 89) Number 4

DSS received report of physical and medical neglect on 11-3-89. Baby girl was born prematurely weighing 2 pounds. Cause of the premature birth was abruptio placentae which is often associated with maternal cocaine use. Parents called NICU about once a week. Baby girl was brought young home on APNEA monitor, and mother needed training for its use (11-6-89).

Maternal grandmother visited baby at hospital. She was concerned about the children. Says the house is infested with roaches and rats. She was she has been told her daughter is on drugs. (11-14-89).

A_____ had been good mother until her involvement with M, the baby's father. She says he deals in drugs, and A_____ is using with him (11-16-89).

Mother admitted to using cocaine while pregnant. She said she didn't use it real often since she was pregnant, only when M sold it and had leftovers. Many girlfriends lived with A_____ and M_____ because M_____ had available drugs (11-20-93).

Drug rehabilitation worker reported mother had flat affect and was fairly resistent to counseling. She appeared resentful of someone telling her to go off the cocaine. Also had no conception of time thinking that baby was in hospital 4 weeks rather than actual 2 1/2 months. Worker indicated mother did not seem to care about anything (1-17-90).

The baby, M_____, is very tiny to be almost a year. Mother plans to take her to clinic for appointment. Court Hearing: the court adopted the guardian AD-Litem Treatment Plan. A is not going to drug treatment. NA would be better for mother. As she would have a new group and go three times per week (8-20-93).

Caseworker visited with client and children. Apartment was spotless. Children are well behaved and happy. Health Department determined child has lead poisoning (11-9-90).

M_____ has appointment with Center for Developmental Pediatrics. She is very tiny and weighs 16 pounds (1-30-90).

Mother pregnant but has missed OB appointments. She started using "crack" cocaine in June. She said she has been using the oven to heat the house. Mother due to deliver last of December. Father, WJ, in jail for assualt and battery (10-7-91).

Mother scheduled to enter N.G. Drug Treatment Hospital on 10-25-91. Loss of money to pay utilities was a result of mother using "crack" cocaine, and smoking it in a pipe. She considered releasing urborn baby for adoption but decided against it (12-9-91).

Conclusion

1. As teachers, you must be aware of dysfunctional family life. How will a child appear who lives in a dysfunctional home?
2. Try to imagine parenting in a "using" home. What effects will be transmitted to your student(s) from a child who lives with drug abuse?
3. How will peers relate to the child whose family is under the influence of addiction?
4. What positive strategies will you employ to assist the family? How will you work with multidiscyplinary professionals?
5. Of the effects previously noted, what personality traits might the child and family exhibit who regularly use illicit drugs?
6. For each case reported, mention the most distinguishing feature of the maternal addict that is unlike the other cases reported.

Number One _____

Number Two _____

Number Three _____

Number Four _____

Table 1

Emotional, Mental, Physical, and Behavioral Characteristics of Individuals Reared in Dysfunctional Families[a]

Emotional	Mental	Physical	Behavioral
- fear	- thinking in absolutes	- tense shoulders	- crisis oriented living
- anger			
- hurt	- lack of information	- lower back pain	- manipulative behavior
- resentment	- compulsive thinking	- sexual dysfunction	- intimacy problems
- loneliness	- indecision	- gastrointestinal disorders	- tries to fit in
- sadness	- learning disabilities		- compulsive-addictive
- shame	- confusion	- stress related behaviors	- dysfunction
- guilt	- hypervigilence		
- numbness		- allergies	

[a] Source: Kritsberg, W. (1985). The adult children of alcoholic syndrome: From discovery to recovery. New York: Bantam Books, p. 39.

Table 2

Guidelines for Obtaining Urine Drug Tests[a]

The following are guidelines to assist health-care providers in determining the need to test an infants urine for substances abused by mother during the antepartum period.

1. Mother with no prenatal care, or infrequent (< 5 visits) or late prenatal care (after 28 weeks).
2. Undocumented prenatal care or care in clinics in areas with a high incidence of drug use.
3. Drug use by history anytime in the antepartum period.
4. Previous drug-affected infant.
5. Previous abuse of marijuana, cocaine, heroin, amphetamines, or alcohol.
6. Participation in a substance abuse program.
7. Physical evidence of drug use in the mother, eg. track marks or hepatitis.
8. Drug use in the home by family members or support persons.
9. Abnormal neuobehavioral activity seen in the mother, infant, or support person, eg. signs of intoxication or withdrawal.
10. Involvement with the juvenile or criminal justice system.
11. Prostitution
12. Mutually sexually transmitted diseases, including human immunodeficiency virus.
13. Multiple episodes of fetal wastage (abortions and stillbirths), abruption, prematurity, placenta previa, precipitious delivery, or premature rupture of membranes.
14. Poor maternal weight gain.
15. Prematurity, intrauterine growth retardation, small for gestational age, or microcephaly.

a Used with permission by Bays, J. (1992). The care of alcohol and drug affected infants. Pediatric Annals, 21, 485-497.

Table 3

Specialized Programs Designed by the Child Welfare System that Recommend Service Delivery for Strengthening Families[a]

- Specialized medical care and health services for both the mother and children.
- Periodic home visits by a public health nurse.
- Early childhood and parent education.
- Peer group support and education.
- Temporary and theraputic foster care and specialized respite care.
- Child care.
- Employment and training services.
- Transportation.
- Income assistance.
- Extended family support and counseling.

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